		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019091

Facility Name: NORTHWEST HOME FOR THE AGED

Address: 6300 N. CALIFORNIA (Number) CHICAGO (City) 60659 (Zip Code)

County: COOK

Telephone Number: (773) 973-1900 **Fax #** (773) 973-1904

IDPA ID Number: 36-2216170

Date of Initial License for Current Owners: 02/01/73

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) FRED OSKIN
(Title) ADMINISTRATOR

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	164	Skilled (SNF)	164	59,860	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	164	TOTALS	164	59,860	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,810	4,186	1,777	21,773	8
9	SNF/PED					9
10	ICF	15,439	6,688		22,127	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,249	10,874	1,777	43,900	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.34%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/ 1 /73

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 164 and days of care provided 1,777

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	322,073	60,676	8,855	391,604		391,604		391,604			1
2	Food Purchase		289,767		289,767	(49,823)	239,944		239,944			2
3	Housekeeping	310,233	57,663		367,896		367,896		367,896			3
4	Laundry	140,293	15,203		155,496		155,496		155,496			4
5	Heat and Other Utilities			136,605	136,605		136,605		136,605			5
6	Maintenance	85,876	34,618	51,823	172,317		172,317	1,333	173,650			6
7	Other (specify):*			35,483	35,483		35,483		35,483			7
8	TOTAL General Services	858,475	457,927	232,766	1,549,168	(49,823)	1,499,345	1,333	1,500,678			8
	B. Health Care and Programs											
9	Medical Director			4,160	4,160		4,160		4,160			9
10	Nursing and Medical Records	2,445,739	211,195	66,793	2,723,727		2,723,727		2,723,727			10
10a	Therapy	197,404		16,751	214,155		214,155		214,155			10a
11	Activities	148,991	27,107		176,098		176,098		176,098			11
12	Social Services	114,583			114,583		114,583		114,583			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,906,717	238,302	87,704	3,232,723		3,232,723		3,232,723			16
	C. General Administration											
17	Administrative	112,325			112,325		112,325		112,325			17
18	Directors Fees											18
19	Professional Services			107,851	107,851		107,851		107,851			19
20	Dues, Fees, Subscriptions & Promotions			57,380	57,380		57,380	(24,794)	32,586			20
21	Clerical & General Office Expenses	164,059	32,938	61,257	258,254		258,254		258,254			21
22	Employee Benefits & Payroll Taxes			868,040	868,040	49,823	917,863		917,863			22
23	Inservice Training & Education			5,477	5,477		5,477		5,477			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			4,331	4,331		4,331		4,331			25
26	Insurance-Prop.Liab.Malpractice			185,828	185,828		185,828		185,828			26
27	Other (specify):*			64,426	64,426		64,426	(64,426)				27
28	TOTAL General Administration	276,384	32,938	1,354,590	1,663,912	49,823	1,713,735	(89,220)	1,624,515			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,041,576	729,167	1,675,060	6,445,803		6,445,803	(87,887)	6,357,916			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED #0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			244,176	244,176		244,176		244,176			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **amort comp soft**			5,897	5,897		5,897		5,897			36
37	**TOTAL Ownership**			250,073	250,073		250,073		250,073			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		32,943	38,462	71,405		71,405		71,405			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			89,790	89,790		89,790		89,790			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		32,943	128,252	161,195		161,195		161,195			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,041,576	762,110	2,053,385	6,857,071		6,857,071	(87,887)	6,769,184			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(64,426)	27		24
25	Fund Raising, Advertising and Promotional	(24,794)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	1,333			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (87,887)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (87,887)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

NORTHWEST HOME FOR THE AGED

ID# 0019091

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1,333	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	1,333		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,333	0	0	0	0	0	0	0	0	0	0	1,333	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	1,333	0	0	0	0	0	0	0	0	0	0	1,333	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(24,794)	0	0	0	0	0	0	0	0	0	0	(24,794)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(64,426)	0	0	0	0	0	0	0	0	0	0	(64,426)	27
28	**TOTAL General Administration**	(89,220)	0	0	0	0	0	0	0	0	0	0	(89,220)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(87,887)	0	0	0	0	0	0	0	0	0	0	(87,887)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number NORTHWEST HOME FOR THE AGED **#** 0019091 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(87,887)	0	0	0	0	0	0	0	0	0	0	(87,887)	45

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NORTHWEST HOME FOR THE AGED COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0019091

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,536 B. General Construction Type: Exterior BRICK Frame WOOD Number of Stories

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 0
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 0
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	PATIENT CARE	24,221	1993	$ 162,933	1
2					2
3	TOTALS	24,221		$ 162,933	3

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1973	1973	$ 797,821	$ 19,945	40	$ 19,945	$	$ 595,792	4
5	8		1986	1986	418,000	10,450	40	10,450		172,425	5
6	6		1994	1994	682,486	17,052	40	17,052		144,942	6
7											7
8											8
	Improvement Type**										
9	LAND IMPROVEMENT			1973	12,360		10			12,360	9
10	LAND IMPROVEMENT			1981	88,292		10			88,292	10
11	LAND IMPROVEMENT			1982	32,553		10			32,553	11
12	LAND IMPROVEMENT			1983	55,207		10			55,207	12
13	LAND IMPROVEMENT			1984	60,325		10			60,325	13
14	LAND IMPROVEMENT			1985	12,481		20			12,481	14
15	LAND IMPROVEMENT			1986	33,262		20			33,262	15
16	LAND IMPROVEMENT			1986	99,906		20			99,906	16
17	LAND IMPROVEMENT			1987	3,507		10			3,507	17
18	LAND IMPROVEMENT			1988	46,957		10			46,957	18
19	LAND IMPROVEMENT			1989	11,021		10			11,021	19
20	LAND IMPROVEMENT			1989	52,943		10			52,943	20
21	LAND IMPROVEMENT			1993	1,500	150	20	150		1,425	21
22	BUILDING IMPROVEMENT			1973	314,578		20			314,578	22
23	BUILDING IMPROVEMENT			1974	7,564		40			7,564	23
24	BUILDING IMPROVEMENT			1975	24,726		20			24,726	24
25	BUILDING IMPROVEMENT			1976	61,018		20			61,018	25
26	BUILDING IMPROVEMENT			1977	16,352		20			16,352	26
27	BUILDING IMPROVEMENT			1978	3,161		20			3,161	27
28	BUILDING IMPROVEMENT			1979	77,150		20			77,150	28
29	BUILDING IMPROVEMENT			1980	36,176		20			36,176	29
30	BUILDING IMPROVEMENT			1981	24,284		20			24,284	30
31	BUILDING IMPROVEMENT			1982	11,976	276	20	276		11,976	31
32	BUILDING IMPROVEMENT			1983	51,666	2,584	20	2,584		49,963	32
33	BUILDING IMPROVEMENT			1984	62,215	3,110	20	3,110		57,535	33
34	BUILDING IMPROVEMENT			1985	16,770	838	20	838		14,665	34
35	BUILDING IMPROVEMENT			1986	37,684	1,884	20	1,884		31,086	35
36	BUILDING IMPROVEMENT			1987	82,905	4,145	20	4,145		64,248	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	BUILDING IMPROVEMENT	1988	$ 47,481	$ 2,374	20	$ 2,374	$	$ 34,423	37
38	BUILDING IMPROVEMENT	1990	74,626		10			74,626	38
39	BUILDING IMPROVEMENT	1991	425		10			425	39
40	BUILDING IMPROVEMENT	1991	5,901	295	20	295		3,393	40
41	BUILDING IMPROVEMENT	1992	1,755	88	20	88		924	41
42	BUILDING IMPROVEMENT	1993	86,526	4,326	20	4,326		41,097	42
43	BUILDING IMPROVEMENT	1994	64,428	3,222	20	3,222		27,387	43
44	AIR INTAKE	1995	3,899	194	20	194		1,455	44
45	WATER MIXING VALUE	1995	1,474	74	20	74		555	45
46	LAVETORY FAUCENTS	1995	3,662	183	20	183		1,373	46
47	HOT WATER SYSTEM	1995	10,982	549	20	549		4,118	47
48	BATH TUB SLIPRESISTENT	1995	2,700	135	20	135		1,012	48
49	GENERATOR	1995	22,900	1,145	20	1,145		8,588	49
50	NEW WALL	1996	1,405	70	20	70		455	50
51	RETURN DUCK	1996	528	26	20	26		169	51
52	H20 WATER HEATER	1996	10,711	536	20	536		3,484	52
53	H20 BOOSTER	1996	14,484	724	20	724		4,706	53
54	NEW WINDOWS	1996	763	38	20	38		247	54
55	ROOF	1996	6,000	300	20	300		1,950	55
56	SEWER SYSTEM	1996	2,350	118	20	118		767	56
57	NEW DECK	1996	6,100	305	20	305		1,983	57
58	SERVICE SWITCH	1996	820	41	20	41		266	58
59	ELECTRICAL	1996	2,905	145	20	145		943	59
60	GUTTER BOX	1996	625	31	20	31		202	60
61	ELECTRICAL WORK	1996	3,300	165	20	165		1,072	61
62	ELECTRICAL SERVICE	1996	590	30	20	30		195	62
63	ELECTRONIC MAGNETIC DOOR	1996	624	31	20	31		202	63
64	FIRE DOORS	1996	10,100	505	20	505		3,282	64
65	BOILDER FLUE PIPE	1996	2,296	115	20	115		747	65
66	HORIZONTAL WATER COOLED A/C	1996	9,000	450	20	450		2,925	66
67	NEW PUMPS	1996	9,875	494	20	494		3,211	67
68	NEW VALVES	1996	2,368	118	20	118		767	68
69	ROOF	1997	35,350	1,767	20	1,767		9,719	69
70	TOTAL (lines 4 thru 69)		$ 3,683,799	$ 79,028		$ 79,028	$	$ 2,454,548	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,683,799	$ 79,028		$ 79,028	$	$ 2,454,548	1
2	NEW BATHROOM FLOORS	1997	3,198	160	20	160		880	2
3	MANHOLE REPAIR	1998	2,350	117	20	117		527	3
4	TILING	1998	23,105	1,155	20	1,155		5,198	4
5	ROOF TOP UNIT	1998	6,370	319	20	319		1,435	5
6	CUSOM CABINTRY	1999	3,300	165	20	165		578	6
7	CONCRETE RAMPS	1999	2,000	100	20	100		350	7
8	SLIDING DOOR	1999	9,046	452	20	452		1,582	8
9	TILING	1999	6,679	334	20	334		1,169	9
10	PERIMITER PLASTIC	1999	2,250	112	20	112		392	10
11	WINDOWS	1999	4,760	238	20	238		833	11
12	NEW MANHOLE	1999	3,180	159	20	159		557	12
13	DRAIN PIPES	1999	2,800	140	20	140		490	13
14	KICK PLATES	1999	4,070	204	20	204		714	14
15	COOLING EQUIPMENT	1999	8,142	407	20	407		1,424	15
16	ELECTRIC EYE	1999	3,141	157	20	157		550	16
17	WINDOWS	2000	1,076	54	20	54		135	17
18	SIGN	2000	6,150	307	20	307		768	18
19	FLOORING	2000	7,312	366	20	366		915	19
20	CUBICLE CURTAINS	2001	10,147	507	20	507		761	20
21	WINDOWS	2001	2,060	103	20	103		154	21
22	ELEVATOR REHAB	2001	20,485	1,024	20	1,024		1,536	22
23	DRAINS AND GREASE TRAPS	2001	3,500	175	20	175		87	23
24	CONDENSING UNITS AND WIRING	2001	9,965	498	20	498		175	24
25	TILING	2001	82,110	4,106	20	4,106		6,159	25
26	OVERBED LIGHTS AND SCONCES	2001	28,520	1,426	20	1,426		2,439	26
27	STEEL DOORS	2001	2,640	132	20	132		198	27
28	WALLCOVERINGS	2001	4,168	208	20	208		312	28
29	CORNICES WITH BLACKOUT LINED DRAPERY	2001	18,276	914	20	914		1,371	29
30	FLOORING	2001	31,589	1,580	20	1,580		2,370	30
31	PAINTING	2001	48,425	2,421	20	2,421		3,632	31
32	CORNICES	2001	8,833	442	20	442		663	32
33	CRASHBARS, WALL BORDERS & CORNERGUARDS	2001	29,120	1,456	20	1,456		2,184	33
34	TOTAL (lines 1 thru 33)		$ 4,082,566	$ 98,966		$ 98,966	$	$ 2,495,086	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,082,566	$ 98,966		$ 98,966	$	$ 2,495,086	1
2	CORNICES, CORNER GUARDS & CUBICLE TRACKS	2001	15,202	760	20	760		1,140	2
3	BUILT-IN WARDROBES	2001	54,924	2,746	20	2,746		4,119	3
4	TILING, WALLPAPER & PAINTING 4 BATHROOMS	2001	11,741	587	20	587		881	4
5	SCONCES	2001	1,179	59	20	59		89	5
6	CORNER GUARDS	2001	345	17	20	17		26	6
7	AMBULANCE DOOR	2001	420	21	20	21		31	7
8	WALLCOVERING	2001	2,288	115	20	115		172	8
9	CUSTOM ORDER SCREEN SPRINT	2001	9,825	491	20	491		736	9
10	CARPETING	2001	8,810	441	20	441		661	10
11	VINYL FLOORING IN ACTIVITY ROOM	2001	5,287	264	20	264		396	11
12	CROWN MOLDING & HANDRAILS	2001	7,266	363	20	363		545	12
13	CRASH RAILS & BED LOCATORS	2001	9,322	466	20	466		699	13
14	CRASH RAILS	2001	3,346	167	20	167		251	14
15	CORNER GUARDS	2001	563	28	20	28		42	15
16	CEILING	2001	13,271	664	20	664		1,013	16
17	SCONCES	2001	1,915	191	10	191		191	17
18	PAINTING	2001	5,214	521	10	521		521	18
19	CUBICLE CURTAINS	2001	788	79	10	79		79	19
20	CARPETING & COVE BASE	2001	10,000	1,000	10	1,000		1,000	20
21	LAND IMPROVEMENT-CONCRETE WORK	2002	4,100	205	10	205		205	21
22	BLINDS	2002	658	33	10	33		33	22
23	CORNICE & DRAPES	2002	4,721	236	10	236		236	23
24	DOORS	2002	12,752	319	20	319		319	24
25	CEILING TILE	2002	1,926	48	20	48		48	25
26	FIRE CODE WORK	2002	80,256	2,007	20	2,007		2,007	26
27	FLOORING	2002	4,721	118	20	118		118	27
28	WALLS	2002	8,824	221	20	221		221	28
29	CEILING SYSTEM	2002	8,507	213	20	213		213	29
30	RECESSED DOWNLIGHTS	2002	602	15	20	15		15	30
31	WIRING	2002	6,195	154	20	154		154	31
32	EXIT DOOR ALRM CONTROL PANEL	2002	1,130	28	20	28		28	32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,378,664	$ 111,543		$ 111,543	$	$ 2,511,275	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,241,603	$ 128,501	$ 128,501	$	5-10 YRS	$ 890,270	71
72	Current Year Purchases	31,456	1,573	1,573		10 YRS	1,573	72
73	Fully Depreciated Assets	350,131					350,131	73
74								74
75	TOTALS	$ 1,623,190	$ 130,074	$ 130,074	$		$ 1,241,974	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1998 CHRYSLER T & C	1997	$ 26,467	$ 2,559	$ 2,559	$	5	$ 26,467	76
77										77
78										78
79										79
80	TOTALS			$ 26,467	$ 2,559	$ 2,559	$		$ 26,467	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,191,254	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 244,176	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 244,176	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,779,716	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 754	$		$ 754	1
2	Licensed Speech and Language Development Therapist		hrs			2,735			2,735	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			11,814			11,814	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				32,943		32,943	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): REHAB,LABORAT.					23,159			23,159	13
14	TOTAL			$		$ 38,462	$ 32,943		$ 71,405	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED **#** 0019091 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 89,303	$	1
2	Cash-Patient Deposits	(161)		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,302,328		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	231,151		6
7	Other Prepaid Expenses	2,440		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,625,061	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	677,347		13
14	Buildings, at Historical Cost	1,898,307		14
15	Leasehold Improvements, at Historical Cost	1,965,944		15
16	Equipment, at Historical Cost	1,695,650		16
17	Accumulated Depreciation (book methods)	(3,821,769)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,415,479	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,040,540	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 187,385	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	212		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	367,775		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation	125,916		34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	INTERFUND TRANSFER	3,834,055		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,515,343	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,515,343	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (474,803)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,040,540	$	48

***(See instructions.)**

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 427,649	1
2	Restatements (describe):		2
3	POST CLOSING AUDIT ADJUSTMENT	336,779	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 764,428	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,239,231)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,239,231)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (474,803)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,411,250	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,411,250	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(17,217)	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ (17,217)	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(34)	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (34)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,112	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,112	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSIONS	607	28
28a	CONTRIBUTION & MISC INCOME	222,122	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 222,729	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,617,840	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,549,168	31
32	Health Care	3,232,723	32
33	General Administration	1,663,912	33
	B. Capital Expense		
34	Ownership	250,073	34
	C. Ancillary Expense		
35	Special Cost Centers	71,405	35
36	Provider Participation Fee	89,790	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,857,071	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,239,231)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,239,231)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,824	2,026	$ 68,722	$ 33.92	1
2	Assistant Director of Nursing	2,152	2,716	73,821	27.18	2
3	Registered Nurses	27,017	30,527	780,391	25.56	3
4	Licensed Practical Nurses	11,718	13,274	247,183	18.62	4
5	Nurse Aides & Orderlies	88,775	97,752	1,047,370	10.71	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	12,252	14,124	197,404	13.98	8
9	Activity Director	2,072	2,317	47,469	20.49	9
10	Activity Assistants	7,317	8,535	101,522	11.89	10
11	Social Service Workers	5,516	6,376	114,583	17.97	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,908	2,099	34,245	16.31	14
15	Cook Helpers/Assistants	28,640	31,535	287,828	9.13	15
16	Dishwashers					16
17	Maintenance Workers	4,104	4,910	85,876	17.49	17
18	Housekeepers	27,958	31,069	310,233	9.99	18
19	Laundry	12,785	14,785	140,293	9.49	19
20	Administrator	1,824	2,080	112,325	54.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,310	7,234	164,059	22.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,847	7,721	110,166	14.27	31
32	Other Health Care(specify)	4,507	5,748	118,086	20.54	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	253,526	284,828	$ 4,041,576 *	$ 14.19	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	monthly fees	$ 8,855	1-3	35
36	Medical Director	monthly fees	4,160	9-3	36
37	Medical Records Consultant	monthly fees	3,120	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	monthly fees	5,340	10-3	39
40	Physical Therapy Consultant	monthly fees	8,236	10a-3	40
41	Occupational Therapy Consultant	monthly fees	8,515	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant		0	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 38,226		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	182	$ 9,196	10-3	50
51	Licensed Practical Nurses	120	4,381	10-3	51
52	Nurse Aides	94	2,183	10-3	52
53	TOTAL (lines 50 - 52)	396	$ 15,760		53

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
FRED OSKIN	ADMIN	0	$ 112,325
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 112,325

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		107,851
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 107,851

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 175,843
Unemployment Compensation Insurance	9,486
FICA Taxes	309,042
Employee Health Insurance	295,957
Employee Meals	49,823
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	28,308
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	49,404
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 917,863

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	21,091
Health Care Worker Background Check	1,040
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	24,794
TRUST/FRANCHISE/CONTRIB/ETC	0
LICENSES & PERMITS	600
DUES & SUBSCRIPTIONS	9,855
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(24,794)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,586

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATIN	6/99	$ 7,994	3 YRS	$ 1,333	$ 2,664	$ 2,664	$ 1,333	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 7,994		$ 1,333	$ 2,664	$ 2,664	$ 1,333	$	$	$	$	$

Facility Name & ID Number NORTHWEST HOME FOR THE AGED # 0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? _____
If YES, give association name and amount. _____

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **48,587** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **89,790**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **49,823** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: NORTHWEST HOME FOR THE AGED #0019091 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,855	
	REPAIRS & MAINTENANCE		0	
			0	8,855
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		56,303	
	ELECTRICITY		80,302	
	WATER		0	
	CABLE TV - LOBBY		0	
			0	136,605
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,718	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		31,570	
	ELEVATOR MAINTENANCE & REPAIR		12,094	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,441	
	FIRE SERVICE		0	
			0	
			0	
			0	51,823
7	**OTHER**			
	SCAVENGER		35,483	
	SECURITY SERVICE		0	35,483
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,160	4,160

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	15,760	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	3,120	
	PHARMACY CONSULTANT	XVIII B 39-2	5,340	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	20,288	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	ACTIVITY VOLUNTEER LABOR		22,285	
			0	66,793
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	8,236	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	8,515	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	16,751
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number NORTHWEST HOME FOR THE AGED **#0019091** **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	13,966	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	93,885	
			0	107,851
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	24,794	
	EMPLOYEE WANT ADS	XIX F	21,091	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	9,855	
	LICENSES & PERMITS	XIX F	600	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,040	57,380
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		29,235	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		32,022	
	MESSENGER SERVICE		0	
			0	61,257

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	309,042	
	UNEMPLOYMENT COMPENSATION	XIX D	9,486	
	WORKERS COMPENSATION INSURANC	XIX D	175,843	
	HOSPITALIZATION INSURANCE	XIX D	295,957	
	EMPLOYEE BENEFITS - OTHER	XIX D	28,308	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	49,404	
	CHICAGO HEAD TAX	XIX D	0	868,040
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		5,477	5,477
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		4,331	4,331
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		185,828	185,828
27	**OTHER**			
	BAD DEBTS	VI 24	64,426	
			0	64,426

GRAND TOTAL COLUMN 3 OTHER 1,675,060

NORTHWEST HOME FOR THE AGED
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	289,767
LESS SALES TAX	0
NET FOOD	289,767
TOTAL PATIENT CENSUS	43,900
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	131700
ADD # EMPLOYEE MEALS/DAY	75
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	27375

PATIENT MEALS	131700
ADD EMPLOYEE MEALS	27375
TOTAL MEALS/YEAR	159075
NET FOOD	289767
DIVIDE TOTAL MEALS/YEAR	159075
COST PER MEAL	1.82
TIME EMPLOYEE MEALS	27375
EMPLOYEE MEAL RECLASSIFICATION	49823